OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 5 February 2015 commencing at 10.00 am and finishing at 1.10pm

Present:

Voting Members:	Councillor Yvonne Constance OBE – in the Chair
	Councillor Susanna Pressel (Deputy Chairman) Councillor Kevin Bulmer Councillor Surinder Dhesi Councillor Tim Hallchurch MBE Councillor Laura Price Councillor Alison Rooke Councillor Les Sibley District Councillor Alison Thomson District Councillor Dr Christopher Hood District Councillor Rose Stratford Moira Logie Dr Keith Ruddle Mrs Anne Wilkinson
Co-opted Members:	Moira Logie, Dr Keith Ruddle and Anne Wilkinson

Officers:

Whole of meeting	Claire Phillips and Julie Dean (Chief Executive's Office); Director of Public Health

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting together with the following additional documents:

- *Document produced by the South Central Ambulance Service entitled 'RCA Investigation Report' (Agenda Item 4)*

and agreed as set out below. Copies of the agenda and reports agenda, reports and additional document are attached to the signed Minutes.

61/15 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

An apology was received from Cllr Martin Barrett.

62/15 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

There were no declarations of interest.

63/15 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Committee noted that the Chairman had agreed to an address by Councillor Jenny Hannaby prior to agenda item 9 – Outcomes Based Contracting.

At the last meeting of this Committee, Councillor Mrs Judith Heathcoat had expressed concerns about the level of service given by the South Central Ambulance Service (SCAS) at a serious incident they attended on 26 April 2014 in Coleshill. Councillor Mrs Heathcoat gave a resume on the facts and the points she raised at that meeting and then briefed the meeting on developments.

SCAS had attended a meeting of the Coleshill Parish Council in January to report the findings of their investigation, a summary of which is included within the papers for this meeting. Councillor Heathcoat informed the Committee that the villagers of Coleshill were concerned that the village is situated at the edge of the Oxfordshire boundary and, as such, there needed to be an awareness by both the South West Ambulance Service and South Central Ambulance Service of distances to travel. Good intercommunications and reciprocal arrangements between the two Emergency Operation Centres across Trust boundaries and Manager Communication was needed to ensure resilience. While understanding that ambulances could be posted to strategic positions, arrival times were too slow generally and communication between Wiltshire/Swindon and South West group was not working. This resulted in either no service or a number of ambulances arriving for the same incident. Concern was also expressed for areas within the Oxfordshire county boundary carrying an SN or an RG postcode – resulting in wrong assumptions being made on the part of the ambulance services.

64/15 MINUTES

(Agenda No. 3)

To approve the Minutes of the meeting held on 20 November 2014 subject to the following amendments (amendments in bold italics):

- Minute 53/14 – paragraph 3, penultimate sentence, ’due to lack of space at the ***West Oxford*** site’;
- Minute 58/14 – page 11, paragraph 1, sentence 1, ’When asked about the sufficiency of ***car*** parking facilities’.

Matters Arising

- Minute 51/14 relating to Minute 40/14, New Contract for Community Sexual Health Services - it was reported that the new Community Sexual Health Service would now be included on the Agenda for the 23 April 2015 meeting;

- Minute 51/14 relating to Minute 43/14, 'Emerging findings of the non-emergency patient transport services' – officers undertook to follow up their request for the copies of literature prepared by the Trust which had been used to advertise and signpost the changes for patients using the non-emergency transport services;
- Minute 57/14,Emergency Ambulance Services in Oxfordshire, page 9, final paragraph – the Committee noted the executive summary of the serious incident referred to by Councillor Mrs Judith Heathcoat at the last meeting on 20 November 2014 and at this meeting. They requested that they be provided with at least one copy of the full report into the incident and that copies also be given to the complainants and to Coleshill Parish Council. Members also requested that responses to a number of questions, noted below be provided by the Trust prior to their attendance at the next meeting of the Committee on 23 April:

  - Why did the 999 call go to Bristol?
  - What was the reason for the mobile failure in the rapid response vehicle?
  - Why were four dual crewed vehicles out of service that day?
  - Why was there no upgrade of the incident after 45 minutes?
  - What are the protocols for cover during lunch breaks?
  - Why has the report into the incident taken so long to be produced?
  - What reflective practice and learning actions have derived from the incident? What action has been taken on the business continuity plan in light of the main systems failure and problems with call handling?
  - Was there a clinical impact on the patients?
  - How many incidents similar to this have there been?
  - How are first responders used?

65/15 TOOLKIT - METHOD FOR DETERMINING WHETHER A PROPOSED SERVICE VARIATION OR SERVICE DEVELOPMENT IS 'SUBSTANTIAL'.

(Agenda No. 5)

Claire Phillips introduced the proposed, revised Toolkit (JHO5) which had been designed to establish an agreed method for determining whether a proposed service variation or service development was 'substantial', and thus a matter upon which there should be formal consultation with the Committee.

The Committee **AGREED** to adopt the Toolkit.

66/15 HEALTHWATCH OXFORDSHIRE

(Agenda No. 6)

Dermot Roaf, Deputy Chair of Healthwatch Oxfordshire and Rachel Coney, Chief Executive presented their report on the actions taken by commissioners and providers in response to their recommendations since April 2014. It was noted that although some of the recommendations had not been implemented, the intention was to return to them. Healthwatch thanked both providers and commissioners for their assistance and transparency in their recommendation responses. It was also noted that the three areas where targets were being routinely missed, and where there was most concern, were health checks, CAMHS waiting times and cancer treatment time.

The Committee thanked Dermot Roaf and Rachel Coney for their attendance and thanked them for the report.

67/15 PRIMARY MEDICAL SERVICES

(Agenda No. 7)

Ginny Hope from NHS England (Thames Valley Team) and Dr Joe McManners, and Rosie Rowe from the Oxfordshire Clinical Commissioning Group attended the meeting to present an overview of primary medical services and to discuss future challenges and service development within Oxfordshire. Dr Paul Roblin (Local Medical Committee), Dr Ben Riley (Oxford City Federation), and Dr John Harrison (Principal Medical Limited) also attended to give a provider perspective to the discussion.

A briefing which had been prepared by NHS England (Thames Valley team) and the Oxfordshire Clinical Commissioning Group was before the Committee at JHO7.

Dr McManners, Clinical Chair, OCCG, commented that the local Health and Social Care system was dependent on a high quality and well performing primary care system, which, if done well, could play its part in improving the quality of the whole system, including that of secondary care. Whilst Oxfordshire had been recognised as producing a high quality primary care, the role and function of the GP had changed gradually over the years and had reached crisis point. Reasons cited were increased demand for urgent appointments and more and more complex care combined with the expansion of the numbers of people aged 85 and over, less care taking place in hospital, and more preventative care being undertaken with patients. With the amount of resource as a proportion of the Health spend reducing, primary care is trying to do more for less. Dr McManners added that whilst there was much that worked well in primary care, there was a need to cluster groups of practices and integrate work with social care (and communities in local areas) in order to meet these changing needs. Thirdly he highlighted the need for more work to be done on recruitment and retention practices to meet the issues faced by a GP practice in the modern age.

Ginny Hope, Head of Primary Care, NHS England (Thames Valley team) commented that, following the recent reorganisation, NHS England held the legal commissioning contracts with all 80 GP practices across Oxfordshire and the whole of the Thames Valley region (240 GP practices in all, 10 CCGs). She added that the delivery of a high quality health service was being undertaken via co-commissioning with the CCGs and via close working with GPs and providers. NHS England was working with CCGs on different models of working and the transformation of primary care. They were also working with them on a demographic approach, looking to produce a mapping exercise across all counties. In addition, NHS England was also working with CCGs on questions for the new strategy based on expansion prospects and commissioning. She informed the Committee that new funding was available via NHS England from a Primary Care Infrastructure Fund, undertaking to send officers the link to it for circulation to members.

Regarding the link between NHS England and CCGs who are unable to fund the transformation of practices into federations, or did not have the capacity to do so,

Ginny Hope explained that NHS England would take forward the major commissioning, but in time (approximately 12 months). There would be opportunities for CCGs to be able to move from joint-commissioning to delegated commissioning. Dr Harrison commented that it would be possible to work in a larger scale and to operate extended services, but retain traditional primary care services within it, as demonstrated by the Banbury Health Centre.

Dr Ben Riley explained that the Oxford City Federation was a new organisation which had only just formed, representing 22 practices in the City locality. Its aim was to strengthen and support services which could be offered, partly to sustain the skills already in place and also to build on and expand them. Each practice would own a share and it would be run on a not for profit basis.

When questioned about why only 68 out of 80 practices in the County had agreed to follow the federation route, Dr Harrison explained that primary care had remained unchanged in Oxfordshire for many years and some areas were very conservative in nature and felt differently about federation. He made reference to the Prime Minister's Challenge Fund (£4.5m), the aim of which was to fund interventions at a much earlier stage. For example it would fund an elderly visiting service to the frail and elderly at a much earlier stage before their health deteriorated, resulting in visits to A & E. The federation would also be responsible for delivering health checks within primary care and they would be delivered via quality assurance methods. There would also be opportunities to bid for monies from the Prime Minister's Transformational Fund. There were also plans to introduce care navigators which would assist patients to link up with the right services and roll out care plans for patients with complex needs. There would be some linkage of services and sharing of responsibility – and other services such as Oxford Health working alongside. Different components were being piloted as part of a future vision.

Dr Paul Roblin addressed the challenges facing primary care focusing on resourcing to make the transformational changes, gaps in GP entry into the service, and stress levels within the GP service. The Local Medical Committee were keen for services to remain close to where patients live, that the national NHS contract would not be tinkered with, and that there be an integrated, seamless service put in place (to include secondary care), and, as circumstances change, for money and resources to move as appropriate.

Rosie Rowe emphasised that the OCCG and NHS England would be going out to consult on a detailed Strategy and that there were plans to form another cluster of practices covering the Abingdon area.

Dr McWilliam commented that there were several trends that could be expected from GPs in the future which would result in a different patient experience. Surgeries would be grouped into bigger units, would be more commercial, managed more centrally and uniformly and more GPs would be salaried rather than independent.

In response to a question about whether funding from the Better Care Fund would be used for this purpose, Dr McManners and Ginny Hope responded that this would not be the case but there were other pots of money available such as the Funds referred to above. They commented that Oxfordshire was relatively well served for premises.

More investment would be coming and there would also be a focus on working with providers in this context. Dr Roblin added that the national contract (per capita) would not increase and the Government was looking to CCGs to fund the changes.

Dr McManners was asked whether the cut in nurse and nurse practitioners was an issue. He responded that he understood that there was a problem with recruiting sufficient numbers of nurses, however, a number of universities were now training post graduate nurses to work alongside doctors to undertake some of their work. With regard to the recruitment and retention of GPs, Ginny Hope and Dr Roblin referred to a 10 Point Plan which had recently been launched to address this and included incentives for existing GPs not to retire, or to assist GPs to return to the profession more easily. This Plan and federalisation would also make the profession more popular to prospective GPs.

When asked if there was any research on improving access to GPs. Rosie Rowe responded that the answer was closer linkage between health and social care. The Prime Minister's Challenge Fund would provide the resources to ease the interface between staff and encourage closer working. The CCG were working with Oxford Health on the integration of Health and Social Care teams in the localities. Oxford University had been asked to undertake an evaluation of the new ways of working from a patient perspective. Dr McManners commented that there was evidence that continuity of care reduces hospital admissions, though the outcomes were not so strong in urgent cases.

Dr Harrison was asked if the professional ethos which all doctors follow would be affected in a not for profit environment. Both he and Dr Riley responded that the current NHS ethos would be captured in the new organisation.

In response to a question asking where the incentives were to undertake regular visits from GPs to care homes if they were to become salaried, Dr Roblin stated that a scheme would be introduced within the next few months whereby GPs would be given incentives to visit care homes, amounting to £200 per bed.

When asked what arrangements had been made for the provision of new surgeries in new areas of housing growth, Ginny Hope explained that the CCG were trying to map that growth, adding that it needed to balance the long-term sustainability of the small GP practice. Small practices would not be the model, practices with 8,000 – 10,000 patients would be more sustainable.

Ginny Hope was asked about how NHS England planned for its future commissioning of new surgeries. She explained that NHS England was not a statutory consultee in the local authority planning process, but was often included as part of good practice. A more robust process was needed. It was also working with organisations such as Community Health Partnerships and NHS Estates to identify under - utilised, existing estate to ensure that assets were used.

A member asked if GPs would continue to provide a holistic approach to patient care, to which Dr Roblin responded that GPs are imbibed with a holistic ethos and they would hope to provide holistic, whole person medicine.

When asked who would be carrying out the visiting service and what training would be given, Dr Riley responded that the visiting service would remain a GP responsibility. Practices would be engaging emergency care practitioners and senior nurse practitioners who would undertake the visits, supervised by a named GP. Training would be given. All of this would have to be worked through. Doctors were already undertaking out-of-hour services and initial feedback had indicated that it had been successful.

In response to a question about patient information available to those undertaking the visiting service, Dr Harrison stated that the CCG was in the process of building the capability for summarised notes to be included on all patient records.

Dr McWilliam and Dr McManners were asked if systematic preventative care would also be developed as part of primary care going forward, or was it destined for the commercial high street. Dr McManners responded that a substantial amount of work was already undertaken in this sphere, in the early detection of cardio vascular problems for example, but a suitable approach was required and it needed to be worked out. Dr Roblin added that primary prevention had still to be resourced, analysed for its financial benefit and thought given to how primary care may be utilised to the patient's best advantage. A member pointed out that the Banbury Regeneration Programme was an example of good prevention work, to which Dr McManners responded that a team at the CCG gave focus to it and went out to practices and groups with the aim of improving their practices in preventative work and breaking down any existing barriers.

A member asked about whether the use of physiotherapists would be included within primary care, Dr Harrison and Dr McManners responded that this would be included within a forthcoming review of musculo-skeletal services. The proposals included patient self-referral to physiotherapy services, with no filtering taking place. Dr McManners confirmed that it had been proposed that these services would be embedded into GP practices. He suggested that the Committee might wish to feed into the review.

At the conclusion of the discussion, the Committee **AGREED** to:

(a) ask the CCG and NHS England to circulate the consultation document on Primary Care to members of the Committee for comment prior to it going out to the wider public; and

(b) that a recommendation be sent to all the appropriate bodies that NHS England be considered as a statutory consultee partner when housing growth (large and small planning applications) is considered by Councils.

68/15 CHILD & ADOLESCENT MENTAL HEALTH SERVICES REVIEW

(Agenda No. 8)

Sarah Breton, Lead Commissioner, Children, Young People & Maternity Services OCCG/OCC; Donna Clarke, Head of Community Child & Mental Health Services (CAMHS), Oxford Health; Sarah Ainsley, Children, Young People & Families, OCC

and Dr Jonathan McWilliam, Director of Public Health, OCC gave a presentation on the current service and its re-commissioning plans.

The Committee had before them a briefing on the current service its plans for the future(JHO8).

When questioned about why there had been a large increase in referrals last year to CAMHS, Donna Clarke replied that the service had seen a growing number of referrals both locally and nationally. Families could now self - refer and also self - refer back into the service. The recession and consequent strains on the family unit was also a factor and the service was also seeing people with less complex issues than previously, for example, with anxiety. Dr McWilliam and Sarah Ainsley added that the ability to understand and diagnose was better in today's society. Also the public were becoming more aware of the issues associated with abuse and more parents and children were coming forward. Some seek early assistance, others will seek higher level services.

Sarah Breton stated that the pressures on the service were not due to disinvestment in the last 5 years, but were as a result of the pressures in meeting rising demand. She stressed that Oxfordshire ran a good service. Donna Clarke pointed out that in Oxfordshire 100% of emergency referrals were seen on the same day and overall, 73%of young people were being seen within 12 weeks. This was broken down to 50% of young people requiring a Tier 2 service and 23% requiring a Tier 3 or more. Specialist cases were being seen within 12 weeks.

Following a query about the availability of in-county beds for children with a learning disability, Sarah Ainsley stated that the lack of in-patient beds within the county was an issue and there was a need to create more specialist provision in the county for children with a learning disability at transition age, as they tended to stay in adolescence for longer and needed more assistance over a longer period. Sarah Breton pointed out that an-patient bed was the last resort and that Oxfordshire ensured that all the community services were in place, so that people could be cared for in the home. To this end it was incumbent on practitioners to ensure that the correct services/resources were available at the same time. The current consultation in adult mental health services (the Big Plan) was addressing the issues with transition from childhood into adulthood. In addition, Children & Families, in 2014 had had made significant changes in the way the service managed children with a disability, introducing a transition Plan, together with a single Health & Education Plan to ease them over the transition.

Sarah Ainsley, in response to a question regarding looked after children with mental health problems, reported that a significant amount of work was being done with the Children's Programme Board to put in place good placements with foster families. Also, good support was available from Oxford Health focusing on outreach teams giving sustained wrap around care to young people. Referrals could be made by social workers, GPs and schools. With regard to children in custody, Donna Parke stated that Oxford Health had been just been successful in initiating a liaison diversion scheme whereby children and adults with mental health problems in police stations would be assessed. In addition, there is a forensic CAMHS team, which

covers Oxfordshire, Buckinghamshire and Berkshire works with people on the edge of the system.

The Committee **AGREED** to request the officers write to NHS England expressing concern about the lack of in-patient beds within the county.

69/15 OUTCOMES BASED CONTRACTING

(Agenda No. 9)

At its last meeting, the Committee had looked at the work undertaken by the OCCG to develop outcomes based contracting (OBC) for mental health and older people's services. The Committee asked for further clarity and detail in a number of areas.

The Committee had before them a paper **(JHO9)** which addressed the issues raised and which would form the basis for further discussion.

Catherine Mountford and Barbara Batty, from the OCCG attended the meeting to present the item and to respond to questions.

Prior to discussion, the Committee were addressed by Councillor Jenny Hannaby and it was noted that she had recently attended a OCCG Governing Body meeting and she had been concerned to learn that 25% of patients who were classed as delayed transfers of care would have to leave Oxfordshire hospitals within the month.

Barbara Batty was asked to respond to the concerns of Councillor Hannaby. She stated that there was a recognised need to maintain people within the community but that it was also recognised that patients leaving hospital would require more care when they came out. All organisations were working together trying the relieve pressures on the system and to ultimately meet the targets set.

A member of the Committee asked how the outcomes would be measured. Barbara Batty and Catherine Mountford responded that there were four high level outcomes. Other outcomes, beneath them were being developed to support them. A starting point was agreed and the level of improvement which was expected year on year. The outcomes were currently subject to negotiation and once the contracts had been signed, they would be in the public domain. The Mental Health contract was due to start on 1 April 2015 until 1 April 2016. Each area had very specific indicators. They added that the older people contract was more complex and the service scope was currently under discussion with the providers. The outcomes put forward by the most capable providers were under consideration and would not be agreed for 2015/16.

When asked how it was intended that Committee should engage with the process, Catherine Mountford explained that when the mental health contract was signed, then this would give the Committee the opportunity to talk it through. Members felt that it was unacceptable that the Committee will not get to know the detail until after it had been signed, particularly if it would make major changes to the service. Catherine Mountford and Barbara Batty responded that no service change would be implemented without it being consulted upon and that this stage was only an

indication to providers that their model was liked. No implementation or money would change hands until outcomes had been agreed upon.

Dr McWilliam commented that there were pros and cons to the process. Scrutiny will need to scrutinise whether the outcomes have been successfully achieved and also whether the process has proved satisfactory from the patient and public point of view. There would be a need to stay much more closely with provider and voluntary services and scrutinise them as they come. Providers and commissioners will be scrutinised at the same time.

Barbara Batty informed the Committee that Cambridgeshire and Peterborough were a few steps ahead on OBC and there was information on their CCG website on clinical outcomes.

A member commented that contracts would be let for a longer period and therefore very regular reviews would need to be put in place. Barbara Batty agreed that this is what the CCG wanted to happen. Catherine Mountford added that as well as outcomes the CCG would be building service implantation programmes into the contracts.

It was **AGREED** that Councillors Thomson and Bulmer and Moira Logie would look at the Mental Health contract before it was signed to ascertain if there was a process whereby the Committee could get involved before signature; and report back to the next meeting.

70/15 CHAIRMAN'S REPORT AND FORWARD PLAN

(Agenda No. 10)

The Committee's forward plan was noted and agreed.

Claire Phillips agreed to update members on a number of topics which were on the national political agenda prior to the next meeting.

71/15 DATES OF FUTURE MEETINGS - APRIL 2015 - MARCH 2016

(Agenda No. 11)

The dates of future meetings were noted.

..... in the Chair

Date of signing